

**State of Connecticut:**  
**Implementation Support for State Demonstrations to Integrate Care for Medicare-**  
**Medicaid Enrollees**  
**3/25/13 DRAFT**

(Note: funding opportunity information available at:  
<http://www.grants.gov/search/search.do?mode=VIEW&oppId=212713> )

**1. Proposed Approach**

1.1 Introduction

The health care delivery system in the United States of America, including the health care delivery system for the disenfranchised, has come under increasing scrutiny for high costs and poor accountability on outcomes in relation to the delivery systems in the other developed countries. These issues are pertinent even in the Medicare and Medicaid programs where the government does exercise some of the same rate-setting controls on costs that are common in other countries where the government is the dominant payer. Despite the fact that both Medicare and Medicaid have administrative cost ratios much lower than in private insurance, both programs struggle to contain costs, especially where they intersect in the domain for individuals who are Medicare-Medicaid Enrollees (MMEs).

While we make available to these individuals access to the most technologically developed, expensive health care delivery system in the world for them to use without substantial consumer financial contribution, they are often expected to navigate on their own an environment that often includes substandard or inaccessible housing, limited access to healthy food, lack of transportation, loneliness, isolation and despair. For individuals who have intellectual or cognitive disabilities, Serious and Persistent Mental Illness (SPMI), and/or limited English proficiency, merely understanding their role in healthcare and the wellness process may be an enormous challenge. In terms of the twin objectives of diagnosing and treating disease episodes on the one hand and coordinating care and promoting wellness on the other, the US health care system can be said to be at the same time *over-developed* in terms of the escalating and inflationary technologies applied to disease; and *under-developed* in terms of the care coordination and supports provided to the most at-risk members of society.

Connecticut's Demonstration to Integrate Care for Medicare-Medicaid Enrollees seeks to address this dysfunctional dichotomy by enabling person-centered, multi-disciplinary care coordination that will impact both Medicare and Medicaid services and programs by reducing unnecessary areas of over-treatment and/or duplication, addressing areas of unmet need, *and* by integrating medical, behavioral, supplemental and social services to promote a healthier MME population.

1.2 Delivery System Model

For full discussion of the costs and demographic makeup of the current Connecticut (MME) population, please see the “Background” section (Section B) in the proposal that was submitted to CMMI in May, 2012.

Connecticut intends to integrate non-medical, medical, and behavioral Medicare, Medicaid, and supplemental services for MMEs through two models that will rest upon the building blocks of its existing Medicaid and long-term care re-balancing reforms:

**Model 1** (Enhanced Administrative Services Organization): Model 1 will seek to improve health outcomes and care experience of MMEs by enhancing the strengths of Connecticut’s medical and behavioral health ASOs. This model will focus upon expanding and tailoring current Intensive Care Management (ICM) and care coordination capabilities to meet the needs and preferences of MMEs, integrating Medicare data within existing Medicaid-focused predictive modeling and data analytics, as well as enhancing provider use of the same, in support of better integration.

**Model 2** (Health Neighborhoods): Model 2 will launch a new local, person-centered, multi-disciplinary provider arrangement called the Health Neighborhood (HN). This model will focus upon local accountability among providers working together consistent with a MME’s values and preferences through connections that will include care coordination agreements and electronic communication tools, to achieve better integration. Each participating MME will select a Lead Care Management Agency (LCMA) from a range of qualified LCMA’s within the HN. This Lead Care Manager, an employee of the LCMA, will be the single point of contact for the MME, and will coordinate with the full range of each MME’s providers as well as existing, service-specific sources of care coordination including, but not limited to, waiver care managers, Local Mental Health Authority (LMHA) case managers, and Money Follows the Person (MFP) transition coordinators. Each HN will be organized by an Administrative Lead Agency, which will contract with a Behavioral Health Partner Agency and a broad range of providers. Supplemental services included in the model will include chronic disease self-education and management, medication therapy management, nutrition counseling, falls prevention, peer support, and recovery assistance. For more detail on HN organizational structure and composition, please see Appendix *fill in* (Integrated Care Demonstration Operations Plan Outline – Model 2)

Connecticut will require HNs to satisfy and build upon threshold standards for all aspects of the team-based care coordination model.

Each HN will be required to demonstrate participation by a required set of provider members, and may also build upon these standards by incorporating participation by other adjunct participant members.

Each HN will also be required to enter into standard care coordination agreements (provided by the State of Connecticut) with all member providers, which will detail terms including, but not limited to:

- means of communication between MMEs, Lead Care Managers (LCMs), primary care, specialists and other providers;
- means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams;
- role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

Further, HNs will be required to indicate the means through which each Administrative Lead Agency will ensure that provider members receive training to support:

- communication and connections across disciplines;
- specific expectations for the care coordination process; and
- strategies to address care coordination challenges, including, but not limited to, care transitions, urgent scenarios and situations that involve co-occurring conditions.

Additionally, HNs will be required to affirm that they will fulfill the minimum standards for care coordination established by Connecticut. These are more specifically enumerated in Appendix *fill in* (Proposed Minimum Care Coordination Standards for the Integrated Care Demonstration), but generally include:

- standards for enrollment and choice of Lead Care Manager;
- required information disclosures;
- the initial assessment process;
- selection and composition of the members of each multi-disciplinary care team, especially in situations in which there is another source of care coordination support (e.g. a waiver care manager, LMHA case manager or MFP transition coordinator);
- development with the beneficiary of a Demonstration Plan of Care;
- guidelines for implementation, and revision, of Plans of Care; and
- standards for the level of assistance to be provided by Lead Care Managers, summarized below.

The type and frequency of care coordination support that an LCM is providing to each MME will be informed by the level of care coordination support that the MME requires.

Finally, HNs will be obligated to ensure that participants of the Demonstration are afforded various procedural protections in the care coordination process that include the beneficiary acting as the focal point of all Demonstration-related activities, choice of Lead Care Manager, right to switch Lead Care Managers, right to participate in care

planning and development/approval of Demonstration Plans of Care, and right to file a grievance in situations in which beneficiaries do not agree with the terms of a Plan of Care.

Features of the Demonstration that will support both models include:

- chronic illness self-management education activities based on evidence-based practices designed to support MMEs in maintaining or improving the status of chronic conditions including, but not limited to, chronic obstructive pulmonary disease (COPD), asthma, and diabetes;
- a learning collaborative approach to equip providers to connect with one another, to develop capability and cultural competency in serving the needs and preferences of MMEs, and to be knowledgeable about the full range of services and supports that are available to support the whole person needs of MMEs; and
- exploring and facilitating connections to other State and private services and supports that may complement Demonstration activities, including the HUD Healthy Homes Assessment.

**For definitions of key terms, please see Appendix *fill in*.**

### 1.3 Key Tasks

#### 1.3.1 Overall Project Management

The Project Manager for the Connecticut Duals Demonstration will be Kate McEvoy, JD - the Interim Director of the Division of Health Services at the Connecticut Department of Social Services. Ms. McEvoy has been in her present position for over one year now. Prior to joining the management team at DSS she served as an Assistant Comptroller with responsibility for health care policy aspects of the State Employee Health Plan, and previously had over 20 years of experience in the health care field in Connecticut as an advocate.

While Kate will be the Lead Project Manager, her many other responsibilities as the Director of the Connecticut Medicaid program will necessarily limit her role. Supporting Kate in Project Management at DSS will be a full-time Project Director (TBD). Rebecca “Rivka” Weiser (Health Program Assistant II) will be devoted full-time to this project as the Project Coordinator. Additional in-house staff support will be available from the Director of Behavioral Health, the Medical Operations Divisions (Enrollment and the MMIS), the Office of Legal Counsel and Regulatory Affairs (Grievance, Fair Hearings, and Contracts) and the Division of Fiscal Analysis (Budget and Federal Claiming). See Staffing Chart in the Appendix.

Model Description and Enrollment:

The medical Administrative Services Organization, CHNCT, will provide predictive modeling to facilitate member enrollment in the HNs. Individuals who received primary care (or some other types of care, as described in CT's previous application) from an HN participating provider within the twelve months preceding implementation will be passively enrolled into Model 2, the HN model, with the ability to opt out of the HN model. Individuals who did not previously receive such care from an HN provider will be passively enrolled into Model 1, the Enhanced ASO Model. During an open enrollment period, individuals would have the opportunity to choose between Demonstration models before enrollment begins.

### 1.3.2 Model 1 – Enhanced ASO

The Administrative Service Organization (ASO) that is currently contracted to DSS will: 1) perform predictive modeling to facilitate member enrollment in the HNs; 2) provide Intensive Care Management for the MME clients who enroll in Model 1; 3) administer a provider portal through which Primary Care Providers (PCPs), providers and Lead Care Managers (LCMs) under both Models to will be able to access integrated Medicaid and Medicare data

The medical ASO for the State of Connecticut is the Community Health Network of Connecticut (CHNCT). Led by Sylvia Kelly (CEO), CHNCT has held a contract with DSS since the beginning on the HUSKY managed care program in 1995. Beginning on January 1, 2012, CHNCT was given the responsibility to serve as the ASO for all of the health care programs operated by DSS, including the Charter Oak Health Plan (non-Medicaid coverage for adults), HUSKY A (Medicaid families), HUSKY B (CHIP), HUSKY C (Medicaid long-term care, including MMEs), and HUSKY D (Adult Medicaid).

CHNCT will serve as the “back office” and continue their current operations including analytics, predictive modeling, care management, and member and provider support. CHNCT's ability to provide Intensive Care Management (ICM) for high-risk has been limited by the lack of integrated Medicare claims to use in predictive modeling. With the addition of the linked Medicare/Medicaid dataset, CHNCT will be able to expand their ICM activities to the MME population in Model 1. New care management staff will be hired for the Demonstration in order to provide ICM to this newly identified population. At the same time, these data will allow CHNCT to use powerful predictive modeling tools to facilitate member enrollment and improve overall care coordination in Model 2 (HNs).

Connecticut is fortunate to have in place long-standing contracts with ASOs for both medical and behavioral health services. Value Options has a long history with Connecticut Medicaid; first as a subcontractor with one of the managed care organizations (MCOs), and later as the ASO charged with implementing a carve-out of behavioral health services for HUSKY A and HUSKY B. In 2012, Value Options assumed responsibility for the management of behavioral health services for the entire Medicaid program, working closely with partners at the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF).

The linked data will be provided under an agreement with JEN Associates. JEN has completed a linked Medicare-Medicaid dataset for 2010 and will update this dataset for 2011 prior to the project implementation date. CHNCT will in support of both Models 1 & 2 perform predictive modeling using this data, and will also share data on MMEs as well as data on which providers and care managers will be able to make peer comparisons through the CHNCT provider portal.

### 1.3.3 Model 2 – Health Neighborhoods

Under Model 2, DSS will conduct a procurement to secure contracts with the Health Neighborhoods (HNs). HNs will be comprised of a wide array of providers, such as primary care (independent practitioners, FQHCs, clinics) and physician specialty practices, behavioral health providers, LTSS providers, hospitals, nursing facilities, home health providers, hospice providers, pharmacists and identified affiliate service providers (e.g. housing providers, volunteer organizations).

Potential venues for the Health Neighborhoods have been identified in the MME cluster analysis prepared by JEN Associates. This analysis identified naturally occurring groups of MMEs who are served by overlapping sets of common providers. The JEN linked dataset that will provide the basis for this analysis is a key element in program design and rate setting.

The Department will outline in the RFP detailed standards for administration and composition of HN applicants, including leadership, the minimum required array of providers, the incidence of providers relative to the number of MMEs who will be served, and the role of affiliate service providers. Please see Appendices *fill in letter* (Integrated Care Demonstration Operating Plan Outline – Model 2: Health Neighborhoods) & *fill in letter* (Proposed Minimum Care Coordination Standards for the Integrated Care Demonstration) for working drafts of these standards. Health Neighborhoods that are selected through a procurement process will be eligible to receive a start up payment of up to \$250,000, adjusted for the anticipated size of the enrolled population, to support start-up activities of HNs, including activities such as contracting and connecting providers across disciplines, provider and client education, and data and quality oversight infrastructure.

#### 1.3.3.1 Health Neighborhood Formation and Start Up

An impartial third party contractor will be tasked with supporting providers in connecting with each other across disciplines. This support will be crucial, as the HNs will need to have agreements with an array of participating providers across disciplines that are sufficient to ensure coordinated care for their enrollees. Further, DSS will provide assistance to the selected HN Administrative Lead Agencies including template care coordination agreements, guidance on anti-trust provisions related to health networks and joint purchasing, and ,Data Use Agreements that will authorize participation in the CHN-

CT portal and use of MME's Protected Health Information for Demonstration-related purposes.

#### 1.3.4 Systems and Financial Support - Hewlett Packard (MMIS)

In the managed fee-for-service model, the MMIS is the entity that is responsible for adjudicating provider claims and providing cost and utilization data to the Department and CHNCT. Hewlett Packard (HP) and its predecessor (EDS-Electronic Data Systems) has been the incumbent MMIS contractor since the first certified system in 1985.

Under Model 1, the MMIS will continue to be responsible for all state plan and HCBS waiver fee-for-service payments, and will be responsible for the enhanced care coordination payments (APM 1) made directly to the designated patient-centered medical homes (PCMH) for the delivery of enhanced primary care to the MME population.

Under Model 2, HP's role would be similar in that it will be responsible for fee-for-service state plan and waiver service payments and the APM 2 payments that will be paid to the Lead Care Management Agencies in the Health Neighborhoods. These payments will differ from the APM 1 payments by procedure code and content. They will include reimbursement for the care coordination activities undertaken by the Lead Care Managers (LCMs).

We are still in conversation with HP about the how these APM 2 payments will be issued. Our current thinking is that:

1. An administrative fee will be made to the HN under a direct contract with the Department. This fee, in combination with the start-up funds provided by the demonstration grant, will compensate the activities of the Administrative Lead Agency.
2. The Administrative Lead Agency and Lead Care Management Agencies (which employ LCMs) will be enrolled in the MMIS as billing providers.
3. Lead Care Management Agencies will be enrolled with the MMIS as billing providers as part of each Health Neighborhood and will receive per member per month APM 2 payments as reimbursement for care coordination.
4. LCMs will refer to and arrange for previously described supplemental services (e.g., falls prevention and nutrition counseling) for MMEs. The Department is currently reviewing the best means through which to pay for supplemental services.
5. APM 2 payments will be risk-adjusted by the actuarial consultants (Mercer) to reflect the level of need of the HN participating MMEs.

DSS and its MMIS vendor, HP, will be responsible for the implementation of all the defined systems requirements that touch on claims processing and reporting, including the production of data to performance monitoring and the evaluation of the demonstration

#### 1.3.5 Systems and Member Enrollment – Xerox

Xerox, formerly ACS, has had a long and successful relationship with the Department as an independent enrollment broker dating back to the inception of managed care in 1995. Under a contract amendment, Xerox will provide enrollment services under this Demonstration, including the operation of a call center, the production and distribution of member notices, and enrollment of MMEs in Model 1 or 2 of the Demonstration and documenting choices of LCMs.

Member enrollment in this context is very different than in a capitated approach like managed care. For one thing, MME members will have the opportunity to select a different Lead Care Manager (LCM), opt out of their Health Neighborhood, or Model 2 altogether on a monthly basis. See Appendix *fill in* (Proposed Minimum Care Coordination Standards for the Integrated Care Demonstration) for more detail on procedures related to enrollment. There will be no pure fee-for-service choice available for the MME population that does not involve some form of care coordination, either in Model 1 or Model 2. Note, however, that members of Health Homes will receive care coordination through that model instead of the Demonstration, as described below.

#### 1.3.6 Partnerships with the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS)

DSS, DMHAS, and DDS have worked collaboratively in the development of the Demonstration. At the same time that the State is developing the Demonstration, we are working closely with (DMHAS) on a Health Home State Plan Amendment to develop behavioral Health Homes (HHs) for individuals with particular Serious and Persistent Mental Illness (SPMI) diagnoses.

The Department is sensitive to CMS concerns to not duplicate Medicaid claiming for care coordination in Models 1 and 2 with care coordination activities provided by the future HHs. MMEs who also have HH-qualifying SPMI diagnoses will be permitted to enroll up front in *either* the Demonstration or in HHs. Initial passive enrollment of these individuals will account for existing provider relationships (HN or HH), and rules of attribution will be determined for any MMEs with linkages to both HH and HN providers (for example, accounting for the frequency/strength of the relationship with the providers). All MMEs, regardless of which program they are linked to through claims history, will be provided with further education and information in order to make a meaningful and informed choice about their preferred option to receive care coordination.

#### 1.3.7 CMS Authorities

Upon the submission of this application to continue funding the Demonstration, DSS will immediately begin drafting the Memorandum of Understanding (MOU) with CMS in anticipation of the ultimate approval for the project. The key Terms and Conditions in the MOU will clearly identify the basis for calculation and distribution of shared savings of the agreed upon trend for Medicare and Medicaid expenditures.

DSS will also plan to undertake the development of the enhanced primary care case management (PCCM) state plan amendments to secure Medicaid funding for both APM 1 and APM 2 payments.

Finally, for those amendments to contracts that exceed \$1 million in total value (HP, Xerox, CHNCT, HNs), DSS will submit the required documentation to secure federal approval.

### 1.3.8 Integrated Grievance and Fair Hearing Process

The Department will work with CMS to create a unified Grievance and Appeal process for Medicaid and Medicare Parts A, B, and D based on the following principles:

#### Grievances

All MME enrollees will be able to file grievances, either orally or in writing, directly with the Health Neighborhood and the Division of Health Services at the Department of Social Services. Grievances will address issues around access to and treatment by care coordinators, medical providers and administrative staff of the Health Neighborhoods, CHNCT, or the Department.

#### Appeals

Appeals will address specific denials, partial denials, terminations, suspensions, or reductions in service as result of notices of action (NOAs) issued by the Department.

In order to facilitate a uniform, user-friendly process, the Department will begin the Demonstration with all Medicaid and Medicare appeals and fair hearings processes in place while a unified process is developed, reviewed by the Complex Care Committee, the Connecticut Office of the Attorney General and CMS, and ultimately negotiated with CMS.

The Department will work to streamline and expedite appeals procedures, building upon existing protocols and focusing upon the terms and protections that are most favorable to the MME. The Department will incorporate within the uniform process an independent Ombudsman function and is considering the best means of doing so.

### 1.3.9 Beneficiary Protections

In addition to the Appeals and grievances described above, the Department will include the following core beneficiary protections and provider standards, and will use various means to ensure compliance:

- Beneficiary protections, including:
  1. Right to freedom of choice of providers

2. Right to designate “next friends” to join in care planning
  3. Right to receive care consistent with members’ values and preferences
  4. Rights to Medicaid Fair Hearings and Medicare Grievances and Appeals
  5. Rights under HIPAA to protection of confidentiality of release and use of Protected Health Information (PHI) including informed consent for its release
  6. Right by MMEs to access their health records
  7. Informed consent regarding participation in Intensive Care Management (ICM)
  8. Informed consent regarding enrollment and participation in a Health Neighborhood (e.g. information sharing, shared savings)
  9. All Rights afforded by the Americans with Disabilities Act of 1990
- Requirements for CHNCT, HP, providers, including:
    1. compliance with standards of practice
    2. Demonstration specific service standards (e.g. applied practice of person-centeredness, cultural competency, timeliness, means of after-hour and non-face-to-face contact)
    3. mandatory participation in learning collaborative curriculums
  - Means of ensuring compliance including:
    1. Population studies to monitor outcomes and service delivery (e.g. review of the experience of members with intellectual disabilities or SPMI to assess whether they have experienced access barriers or differential treatment)
    2. Financial and medical audits

### 1.3.9 Data Analysis and Rate Setting

One key to the overall success of the project is the linked Medicare-Medicaid dataset for 2011 claims, and other claims on an ongoing basis. JEN Associates integrated 2010 claims data prior to the expiration of their current contract in November, 2012. The Department is in the process of securing an extension of that contract to provide the 2011 integrated data. This integrated data set will support the following:

1. detail on the originally released Cluster Analysis of MMEs and their providers – this identified geographic areas in which there are naturally occurring incidences of 5,000 or more MMEs but the Department did not release sufficient supporting information to assist providers informing Health Neighborhoods;
2. predictive modeling by CHNCT for both Models 1 and 2 that will stratify MMEs by risk for purposes of Demonstration care coordination; and
3. rate setting activities to be undertaken by Mercer on the calculation of:

- 3.1. trend rates for fiscal years 2014, 2015, and 2016 that will be used in the calculation of program savings and shared savings with the Health Neighborhoods in Model 2; and
- 3.2. per member per month rates for the Care Coordination activities in Model 2 (APM 2) and for PCMHs in both models (APM 1)

In order to participate in shared savings, each Health Neighborhood must meet minimum standards for quality of care and patient outcomes as described in Program Evaluation.

#### 1.3.10 Member Outreach

The Department will prepare member notices and public outreach materials prior to the implementation of the program. In addition to written materials, the department will conduct public forums in collaboration with community based organizations and advocacy groups to educate MMEs about their options to accept or decline enrollment in a Health Neighborhood, the conditions for their approval to share health information, and the beneficiary protections afforded them in both Model 1 and Model 2, including the process for filing Grievances and Appeals. In order to provide this outreach, we will leverage our current working relationships with stakeholders that have been engaged in developing the Demonstration (e.g., consumers, family caregivers and members of circles of support, advocacy groups, clinical and social service providers).

#### 1.3.11 Program Evaluation

Specifically, the Department intends to: 1) use measures that are associated with identified domains to assess the impact of the Health Neighborhood (HN) and ASO model on MMEs as individuals and as a population; 2) identify key strategies (provider array, care coordination, communication tools, etc.) that help to achieve person-centered, integrated care within the ASO and the HNs ; and 3) identify the factors that support success and determine the means by which the Health Neighborhood model and/or the enhanced ASO model can be expanded within Connecticut or other states.

Further, the Department agrees to collect and/or provide data to CMS to inform program management, rate development and the calculation of shared savings with the health Neighborhoods including but not limited to: 1) beneficiary level expenditure data and covered benefits for most recently available three years; 2) a description of any changes to the State plan that affect MMEs during the Demonstration period (e.g., payment rate changes, benefit design, addition or expiration of waivers, etc.); and 3) State supplemental payments to providers (e.g., DSH, UPL) during the three year period.

The performance measures included in the Appendix are a preliminary and minimum set to be used by a contract vendor in Program Evaluation. The Department, in partnership with DDS and DMHAS, will also contract with an evaluator to: 1) conduct studies and surveys, including, but not limited to a goal-oriented patient care study; 2) conduct annual focus groups with MMEs; 3) use integrated person-specific Medicare and Medicaid claims data to make comparisons on population- and diagnosis-specific bases

as well as to identify interrelationships, potential for duplication and occurrence of cost shifting as between Medicare and Medicaid; 4) analyze data from health records and/or other available sources; and 5) analyze data regarding supplemental services to assess their effectiveness and their potential expansion to the larger MME and Medicaid populations. The identified savings are anticipated to be generated from key areas of intervention such as: 1) reduced hospital inpatient readmission rates; 2) reduced hospital inpatient admission rates for potentially preventable hospitalizations; 3) reduced unnecessary emergency department (ED) use; 4) re-balancing to more community-based care, and 5) medication management.

#### 1.3.12 Electronic Health Record Cards

The Department is in the process of developing a Medicaid health information portal. However we do not anticipate that the portal will be fully operational in time to support the implementation of the Demonstration in January, 2014. As an alternative, the Department will plan to secure a contract with a vendor to produce paper cards that will be encoded with PHI including the Plan of Care for each member. The data will be available to participating providers at each health care encounter using a card-reader technology.

## **2. Organizational Capacity**

The Department of Social Services is well qualified to implement an innovative model to address the care coordination needs for the MME population. In 2012 the Department operated within a \$6.5 billion annual budget of which over 80% supported the operation of health care programs including Medicaid (Title XIX), CHIP (Title XXI), ConnPACE (Pharmacy Assistance), CADAP (CT AIDS Drug Assistance Program), and numerous state-funded programs including the Charter Oak Health Plan. Through all of these programs, DSS provides health care to 20% of the 3.5 million residents in the State of Connecticut.

In 2012 Connecticut Medicaid moved to a unique managed fee-for-service approach utilizing the services of an organization that was formerly contracted as a Managed Care Organization (MCO) to provide managed fee-for-service benefits to the entire Medicaid program as an Administrative Service Organization (ASO). This model offers the Department the opportunity to implement the demonstration with reduced administrative costs while ensuring strong fiscal and policy oversight to maintain provider accountability and member benefit protections without the intermediate contractor level formerly occupied by the MCOs.

Stakeholder input is crucial to the success of the project. The Department has worked closely with the Complex Care Committee of the legislative Medical Assistance Program Oversight Council (MAPOC) in the development of the Demonstration, including preparation of this application, and will continue to report to the Committee on progress of the initiative through the life of the Demonstration.

The Department will be accountable for implementation and oversight of the Demonstration, and will partner with sister agencies DDS and DMHAS in further development and monitoring of the Demonstration. Key areas of internal support include the Division of Health Services (DHS), the Division of Financial Management & Analysis (DFMA), the Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH), and the Office of Organizational Skill & Development (OSD). Further, contractors that are currently in place will support the Initiative with administrative and consulting functions including claims processing (HP); data integration (JEN); and actuarial analysis and consultation on implementation (Mercer). The Department will utilize and build upon the existing capacities of its medical (CHN-CT), and in partnership with DMHAS, Behavioral Health (ValueOptions) ASO, and work with academic partners and other partners including the University of Connecticut to refine proposed methods of performance measurement. Overall direction in developing and implementing the Demonstration will be provided by a Steering Committee, including representatives from state agencies (DSS, DMHAS, DDS and OPM) and other key stakeholders including consumers and consumer representatives. The Steering Committee will also engage with MMEs and others through such means as focus groups and community town halls to support participation in and feedback on administration of the Demonstration.

The Department plans to procure data integration and analytics support, as well as a means through which to provide electronic communication tools to members of HNs using a card vendor that will produce portable Electronic Health Records (EHRs). Finally, the Department plans to engage an evaluation contractor through which to assess the success of the Demonstration.

Implementation steps associated with enhancing the current ASO model include 1) establishing an applied definition of ICM and development of an ICM/care coordination plan; 2) defining standards for beneficiary protections and customer service; and 3) evaluating and establishing role definition for data analytics and electronic communication tools as between the ASOs, HNs and the CT HIE. Correspondingly, implementation steps associated with procuring the HNs include 1) continued community outreach and engagement to facilitate partnerships among providers; 2) education concerning the model; 3) drafting and issuance of an RFP that defines such features as scope, role of and standards for Administrative Lead Agencies, participation standards, reporting, performance metrics, and shared savings mechanism; 4) issuance of the RFP and procurement process; 5) selection of HNs and contracting; and 6) technical support for HN implementation. Further, the Department plans to draft and disseminate consumer education and rights and responsibilities materials, as well as to draft and issue notices to MMEs and providers regarding the Initiative. Principles of person-centeredness will inform every stage of implementation of the Demonstration, and the Department will use diverse means (stakeholder comment, participant focus groups, and provider learning collaboratives) to inform the operations plan.

### **3. Evaluation and Reporting**

The Department has a robust reporting structure by virtue of its contract with HP to operate the MMIS. This state of the art system is further supported through the ASO contract with CHNCT that includes a sophisticated predictive modeling tool that will provide online claims (both Medicaid and Medicare) through a provider portal to the providers and the Health Neighborhoods and support the management of the members enrolled in the enhanced ASO (Model 1). The planned functionalities for the portal will include claims information, as well as member assessments and Plans of Care.

One of the advantages of this managed fee-for-service approach is that all claims will be processed through a single vendor, the MMIS, thereby eliminating the reporting problems that can arise with the interpretation of encounter data in a traditional managed care model.

Information on expenditures and care plans will be accessible to the management staff at the Department to support the production of the semi-annual progress reports as required by CMS and the actuarial and program evaluation contractors as designated by CMS.

The Department will continue its contractual relationship with JEN Associates to produce the linked Medicare-Medicaid dataset for actuarial analysis and program management. Mercer will provide the actuarial service to calculate shared savings and provide overall project savings information to CMS.

In addition, the department will procure the services of an independent programs evaluator to monitor a comprehensive series of performance indicators and other evaluation activities identified earlier in this document to support continuous progress improvement throughout the life of the Demonstration. While that relationship has yet to be formalized, the Department is considering a contractual relationship with the University of Connecticut Health Center on Aging for that purpose, a distinguished academic center with a long history of research and program evaluation on health care delivery for older adults and people with disabilities.

See the Appendix *fill in* for about a working draft conception of Demonstration performance measures. Connecticut will seek to engage participation by consumers and expert clinician stakeholders in refining and finalization its selection of measures.

#### **4. Budget and Budget Narrative**

*In progress for April 1 submission*

**Appendices:**

**A. Budget**

*In progress for April 1 submission*

**B. Staffing and Organizational Chart**

*In progress for April 1 submission*

**C. Operating Plan**

*Operating Plan documents previously reviewed with the Complex Care Committee are planned for inclusion with the April 1 submission (with revisions).*

**D. Performance Measures**

**See below**

**E. Preliminary Implementation Plan**

*In progress for April 1 submission*

**F. Letters of Support**

*In progress for April 1 submission*

**Appendix D: Performance Measures:**

**A. Performance Measures from Washington State’s MOU**

Connecticut anticipates that the following performance measures (from Washington State’s MFFS MOU) will be included in our MOU with CMS:

<b>Model Core Measures</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
All Cause Hospital Readmission (30-Day All-Cause Risk Standardized Readmission Rate – CMS)	Reporting	Benchmark	Benchmark
Ambulatory Care-Sensitive Condition Hospital Admission (PQI Composite #90)	Reporting	Benchmark	Benchmark
ED Visits for Ambulatory Care-Sensitive Conditions (Rosenthal)	Reporting	Benchmark	Benchmark
Follow-Up after Hospitalization for Mental Illness (NQF #0576)	Reporting	Benchmark	Benchmark
Depression screening and follow-up care (#0418)		Reporting	Benchmark
Care transition record transmitted to health care professional (NQF #648)		Reporting	Reporting
Screening for fall risk (#0101)			Reporting
Initiation and engagement of alcohol and other drug dependent treatment: (a) initiation, (b) engagement (NQF #0004)			Reporting

<b>State-Specific Process Measures: State must select the Health Action Plan and Health Home Network Training Process Measures, and select at least one other process measure [Note: terms to be adapted for Connecticut’s Demonstration]</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Health Action Plans: Percentage of beneficiaries with Health Action Plans within 60 days of beneficiary being assigned to a Care Coordination	Reporting	Benchmark	Benchmark

Organization (Required)			
Training: State delivery of training for Health Home Networks on disability and cultural competence and health action planning (Required)	Benchmark	Benchmark	Benchmark
Discharge Follow-up: Percentage of beneficiaries with 30 days between hospital discharge to first follow-up visit	Benchmark	Benchmark	Benchmark
Real Time Hospital Admission Notifications: Percentage of hospital admission notifications occurring within specified timeframe	Reporting	Benchmark	Benchmark
Percentage of health homes with an agreement to receive data from health home beneficiaries' Medicare Part D Plans	Reporting	Benchmark	Benchmark
<b>State-Specific Demonstration Measures- State must select at least 3, but no more than 5</b>	Year 1	Year 2	Year 3
*State-Specific Demonstration measures – Including LTSS and/or community integration measures	Specified in Final Demonstration Agreement	Specified in Final Demonstration Agreement	Specified in Final Demonstration Agreement

*\*CMS will adapt base measures to incorporate a denominator relative to the Demonstration specific populations at a State level.*

- As also in Washington’s MOU, in order to assess beneficiary experience, the State will work with CMS and its contractors to implement beneficiary and caregiver surveys.

**B. State-Specific Measures:**

In addition to monitoring the above measures and selecting the required 3 to 5 “state-specific demonstration measures”, which we anticipate will be used by CMS in determining retrospective performance payments (shared savings)the Department and the program evaluator will develop a monitoring plan that will include a more comprehensive set of performance measures. These measures will focus on areas identified by stakeholders as priorities (as in our May 2012 application), especially in areas not explicitly addressed by the above measures (such as diabetes care, medication therapy management, and quality of life). We are especially interested in selecting measures from among existing developed measures, as used in relevant measure sets such as:

- The National Quality Forum’s 2012 report: “Measuring Healthcare Quality for the Dual Eligible Beneficiary Population: Final Report to HHS”;
- Medicare Accountable Care Organizations’ quality measures;
- Measures already monitored by CHNCT for our current health care programs